DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PXPU
Facility ID: 00956

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245488**

2.STATE VENDOR OR MEDICAID NO.
(L2) **502043300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WOODLAND**
(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

4. TYPE OF ACTION: 7 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/12/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Stefanie Baumann, HFE - NE II 07/15/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/15/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
07/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/13/2021
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
July 15, 2021

CMS Certification Number (CCN): 245488

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 28, 2021 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Signature block goes here

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 15, 2021

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: CCN: 245488
Cycle Start Date: May 14, 2021

Dear Administrator:

On June 4, 2021, we notified you a remedy was imposed. On July 12, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 28, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 14, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 4, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 28, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

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8. ACCREDITATION STATUS: __ (L10)
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7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **06/30**

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To (b) :

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And/Or Approved Waivers Of The Following Requirements:
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__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

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(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE — Date:
Theresa Gullingsrud, HFE - NE II — 06/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 07/12/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
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24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
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01-Merger, Closure
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered June 4, 2021

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: CCN: 245488
Cycle Start Date: May 14, 2021

Dear Administrator:

On May 14, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

• Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 14, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 14, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 14, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your

obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 14, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Woodland will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 14, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

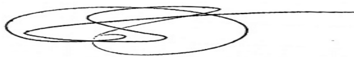
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161   Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING ______ B. WING ______	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE** **BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 5/10/21 through 5/14/21, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with activities of daily living (ADL) for 2 of 2 residents (R21, R7) who were dependent upon staff for assistance. Findings include:	F 677	Disclaimer: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	6/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 06/14/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING ______ B. WING ______	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

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F 677

Continued From page 1

R21's quarterly Minimum Data Set (MDS) dated 4/12/21, identified R21 had severe cognitive impairment. R21 was always incontinent of bowel and bladder, and was fully dependent on staff for toileting and personal hygiene. R21's diagnoses included stroke, diabetes, kidney disease and Alzheimer's disease.

R21's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 10/28/20, identified R21 had no functional bladder control. R21 was no longer able to sit up, required total physical assistance to manage incontinence, total mechanical lift to transfer, and was an assist of one to two staff to manage clothing, hygiene and incontinent products. R21 was no longer able to make their needs known.

R21's care plan dated 1/14/21, directed staff to check and change the resident's incontinence brief every two hours.

R21's current undated Kardex provided 5/13/21, instructed staff to check and change the resident's incontinence brief every two hours.

During continuous observations on 5/12/21, R21 was dressed and seated upright in her wheelchair in the doorway of her room from 7:07 a.m. until 8:11 a.m. when an unidentified staff person wheeled R21 to the dining room and set her at a table for breakfast.

-At 8:47 a.m. R21 was wheeled back to their room by an unidentified staff following breakfast where she remained seated in her wheelchair.

-At 9:14 a.m. nursing assistant (NA)-D entered

F 677

correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual.

1. R21s care plan was reviewed and staff was immediately re-educated on the care planned intervention for checking and changing her.

R7 was re-approached daily for several days and continued to refuse shaving until 5-19-21 at 20:18 when he agreed and staff provided with assistance to remove his facial hair. Staff caring for R7 were provided with education on providing hygiene daily including removal of facial hair as well as how to chart refusal behaviors. Care plan and personal preferences in regards to facial hair was reviewed. R7s care plan was updated to include his preference to be shaved daily but frequently refusal behavior.

2. All residents who are unable to communicate toileting needs or self-perform them are at risk for their toileting plans not being followed. All residents who have preferences for facial hair and are dependent on staff for ADLs are at risk for their preferences not being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING ______ B. WING ______	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 2 R21's room and reclined R21's wheelchair to approximately 20 degrees; however, did not check her brief. -At 9:38 a.m. NA-D peered into R21's room and then continued walking down the hall, without checking to see if incontinence care needed to be completed. -At 9:50 a.m. R21 remained reclined in her wheelchair. During interview on 5/12/21, at 10:05 a.m. NA-D stated R21 got up a little before 7:00 a.m. and staff would be repositioning the resident soon. NA-D identified she looked at the care plan daily and stated R21 needed to be checked and changed every two or three hours as she was always incontinent. On 5/12/21, at 10:17 a.m. NA-D and NA-A used a mechanical lift to transfer R21 from her wheelchair to her bed. NA-D checked R21's brief [3 hours and 10 minutes after the previous check] which was soiled with stool and a small amount of urine. The NA's provided peri care and placed a new incontinence brief. No redness was observed to R21's buttocks. During interview on 5/13/21, at 1:07 p.m. NA-A and NA-E stated the Kardex identified R21 should be checked and changed every two hours. During interview on 5/13/21, at 3:10 p.m. registered nurse (RN)-A stated R21 should be checked and changed every two to three hours. Upon review of the care plan, RN-A clarified the	F 677	followed. DNS and/or designee will review all residents and their care plans and toileting documentation to determine which residents are at risk and begin auditing when they are toileted and if it is within required limits. DNS and/or designee will review all resident preferences for facial hair grooming and update care plans according to preferences. 3. All nursing staff will be re-educated on the policy & procedures, as well as requirement to perform activities of daily living as per the care plan and the residents preferences, specifically including toileting and facial hair grooming as part of an all staff meeting held on Wednesday 6/9/21 and Friday 6/11/21 at multiple times by DNS and/or designee. 4. Audits will be performed on 3 residents, 3 times a week for six weeks by the DNS and/or designee to ensure that facial hair is groomed to the residents' preferences, as well as ensuring that the all residents' care plans are followed for toileting. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. 5. Corrected by 6/28/21	

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F 677	Continued From page 3	F 677		

care plan instructed staff to check and change every two hours and did not direct staff to go up to three hours.

During interview on 5/13/21, at 5:15 p.m. the director of nursing (DON) stated R21 should be checked, changed, and repositioned at a minimum of every two hours, and three hours was an "unacceptable" length of time to go without being checked.

The policy Activities of Daily Living - Rehab/Skills revised 12/28/21, directed staff to provide appropriate treatment to maintain the residents activities of daily living including cleaning after elimination and the changing of protective pads.

R7's quarterly MDS dated 3/8/21, indicated R7 had severe cognitive impairment with no behavioral issues related to refusal of cares. R7 required extensive assistance for personal hygiene/grooming. R7's diagnoses included Alzheimer's disease and metabolic encephalopathy (damage or disease that affected the brain which was not due to injury).

R7's care plan dated 1/27/20, identified R7 preferred to be shaved daily during evening cares.

During observation on 5/10/21, at 5:09 p.m. R7 had rough stubble and was not clean shaven.

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F 677	Continued From page 4 During observation on 5/12/21, at 7:20 a.m. R7 had rough stubble and was not clean shaven. During observation on 5/12/21, at 9:55 a.m. R7 had rough stubble and was not clean shaven. During observation on 5/13/21, at 9:30 a.m. R7 had rough stubble and was not clean shaven. During interview on 5/13/21, at 9:33 a.m. R7 stated he liked to be clean shaven and preferred to be shaved daily. He did not like having stubble on his face. During interview on 5/13/21, at 9:35 a.m. (NA)-A stated R7 should be shaved daily and it was on his care plan. Further R7 had not been shaved since 5/10/21. R7's progress notes from 1/1/21, through 5/10/21, did not identify R7 had refused any offered to shave. During interview on 5/13/21, at 9:36 a.m. trained medication assistant (TMA)-A identified R7's care plan indicated R7 liked to be shaved daily and did not know the last time R7 was shaved. TMA-A stated they did not document resident refusals. During an interview on 5/13/21, at 4:12 p.m. DON stated R7 had facial hair and had not been shaved. Further, there were no refusals of shaving documented. The DON expected R7's care plan to be followed and for R7 to be clean shaven. If a resident refused it should be documented. The facility policy Activities of Daily Living (ADL) dated 12/28/20, indicated ADL's are those	F 677		

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F 677	Continued From page 5 necessary tasks conducted in the normal course of a resident's daily life and identified shaving as daily hygiene/grooming.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide timely repositioning assistance for 1 of 1 residents (R21) who was at risk for pressure ulcer. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/12/21, identified R21 had severe cognitive impairment. R21 was totally dependent on staff and required assistance with transferring and bed mobility. R21 was at risk for pressure ulcers, and was on a turning/repositioning program as an intervention. The MDS did not identify R21 had any current pressure ulcers. R21's diagnoses included stroke, diabetes, and Alzheimer's	F 686	1. Resident's care plan was reviewed regarding repositioning. Care planned intervention for repositioning every two hours was updated to flow to the Kardex for CNA visibility on 6/4/2021 date. 2. All residents with repositioning needs are at risk for pressure ulcers caused by not following their care plans' repositioning schedules. DNS and/or designee have reviewed all residents' care plans and ensure that they are correctly displaying in Kardex so all appropriate staff are able to view. 3. All nursing staff will be re-educated on	6/28/21

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F 686 Continued From page 6
disease.

R21's Positioning Assessment and Evaluation dated 4/12/21, directed staff to reposition R21 every two hours.

R21's care plan dated 1/14/21, identified R21 was at risk for pressure ulcer development and directed staff to reposition R21 every two hours.

During continuous observations on 5/12/21, R21 was dressed and seated upright in her wheelchair in the doorway of her room from 7:07 a.m. until 8:11 a.m. when an unidentified staff person wheeled R21 to the dining room and set her at a table for breakfast.

- At 8:47 a.m. R21 was wheeled back to her room by unidentified staff following breakfast where she remained seated in her wheelchair.

- At 9:14 a.m. nursing assistant (NA)-D entered R21's room and reclined R21's wheelchair to approximately 20 degrees; However, was not offloaded to reduce pressure to her buttocks.

- At 9:38 a.m. NA-D peered into R21's room and then continued walking down the hall.

- At 9:50 a.m. R21 remained reclined in her wheelchair.

During an interview on 5/12/21, at 10:05 a.m. NA-D stated R21 got up a little before 7:00 a.m. and staff would be repositioning the resident soon. NA-D stated R21 needed to be repositioned every two or three hours. NA-D defined repositioning as laying down, as R21 was

F 686

the policy and requirement to preform repositioning as per the care plan as part of an all staff meeting held on Wednesday 6/9/21 and Friday 6/11/21 at multiple times by DNS and/or designee. Additionally all nursing staff who are able to modify the care plan will be educated on how to ensure that the care plan properly triggers items such as repositioning into the Kardex.

4. Audits will be performed on 3 residents, 3 times a week for six weeks by the DNS and/or designee to ensure that residents are being repositioned as required by their care plan. Additional Audits will be performed on 3 residents, 3 times a week for six weeks by the DNS and/or designee to ensure that all relevant items in the care plan are displaying in Kardex. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action.

5. Corrected by 6/28/21

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F 686	Continued From page 7	F 686		

unable to stand, and stated she was not aware of any recent pressure ulcers for R21.

On 5/12/21, at 10:13 a.m. NA-A and NA-D were present in R21's room where R21 was repositioned from her wheelchair to her bed using a mechanical lift [3 hours and 6 minutes after the previous repositioning]. NA-D checked and changed R21's brief and protective barrier cream was applied. R21's buttocks was intact without any redness or pressure ulcers.

During interview on 5/13/21, at 1:07 p.m. NA-A and NA-E stated the Kardex outlined each resident's needs including repositioning and how frequently to check and change a resident's incontinence brief.

R21's Kardex dated 5/13/21, instructed staff to notify the nurse of any new skin issues, provide a pressure relieving mattress and wheelchair cushion, and apply topical barrier cream to buttocks to prevent skin conditions; however, the Kardex lacked any instruction to reposition R21.

During interview on 5/13/21, at 3:10 p.m. registered nurse (RN)-A stated R21 should be repositioned every two to three hours. Upon review of the care plan, RN-A clarified the care plan instructed staff to reposition every two hours and did not direct staff to reposition every two to three hours.

On 5/13/21, at 3:18 p.m. licensed practical nurse (LPN)-A reviewed R21's care plan and stated R21 should be repositioned every two hours. Further, the repositioning instruction in the care plan was not linked to the Kardex, therefore it

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F 686	Continued From page 8 would not appear on the Kardex for the nursing assistants to follow. LPN-A was unsure how to make the edit to ensure the direction showed on the Kardex. During interview on 5/13/21, at 5:15 p.m. the director of nursing (DON) stated R21 should be repositioned at a minimum of every two hours, but more often if there were skin issues. Further, three hours was an "unacceptable" length of time to go without being repositioned for R21. The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled policy reviewed 4/21/21, directed staff to reposition residents who were unable to reposition themselves as often as directed by the care plan.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable	F 880		6/28/21

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F 880	Continued From page 9	F 880		

diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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F 880	Continued From page 10 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was performed to prevent cross contamination for 3 of 4 residents (R26, R2, R21) observed during personal cares. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/26/21, indicated R26 had severe cognitive impairment. R26 required extensive assistance with all activities of daily living (ADL's). R26's diagnoses included non-Alzheimer's dementia, stroke and epilepsy. During observation of moring cares on 5/12/21, at 7:39 a.m. nursing assistant (NA)-C entered R26's room to assist her with getting up and ready. NA-C sanitized her hands and donned a clean pair of gloves. NA-C removed R26's blanket and assisted R26 to sit on the edge of the bed. R26's bed was saturated with urine. R26 was assisted to the bathroom where NA-C removed her urine saturated brief and assisted R26 onto toilet. NA-C assisted R21 with puting on her foot wear and assisted her to get her	F 880	1. All staff were re-educated as to proper hand hygiene and hand washing policy including sanitizing hands after doffing and before donning gloves. 2. All residents are at risk of infection due to improper hand hygiene. 3. An RCA was performed by QAPI coordinator, Administrator, DNS/Infection Preventions, Case Manager, Administrator in training, as well as 4 NA/Rs, 1 RN, 1 TMA, 1 LPN (who were all asked about the barriers that prevented them from performing proper hand hygiene). The result of the RCA was the inconvenience of going to a distance hand sanitizing area. All nursing staff received a personal bottle of hand sanitizer to have as part of their uniform as well as directions of its use and re-education on performing proper hand hygiene. 4. Audits will be performed on 3 staff (or all staff working if under 3) every shift for	

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F 880	Continued From page 11 pants on and got a new brief ready for the resident. NA-C did not remove her gloves or perform hand hygiene after removing the saturated brief. With the same dirty gloves NA-C started preparing a clean wash basin. NA-C then removed the dirty gloves; however, did not wash or sanitizer her hands and then put on clean gloves using dirty hands. NA-C then started to assist R26 to wash her face and upper body. NA-C then assisted her with dressing her upper. NA-C assisted R26 to stand and NA-C removed her dirty gloves. NA-C did not wash or sanitize her hand and then put clean gloves on her using dirty hands. NA-C washed and dried R26's groin and buttocks, applied a barrier cream on R26's bottom then pulled up the brief and her pants. NA-C assisted R26 to the wheel chair. NA-C then removed the dirty gloves; however did not wash or sanitize hands and put clean gloves on using dirty hands and assisted R26 to brush her teeth, wash up around her eyes and comb her hair. After R26 went for breakfast, NA-C stripped the bed, gathered linens and brought them to the dirty utility room. NA-C then removed her gloves and washed her hands with soap and water. During interview on 5/12/21, at 8:18 a.m. NA-C stated she should of either washed or sanitized her hand between glove changes, especially when going from dirty to clean to prevent the spreading urine or feces to other areas. NA-C stated she did not wash or sanitizer her hands between glove changes when caring for R26. During interview on 5/13/21, at 4:12 p.m. the director of nursing (DON) stated she would have	F 880	a week by the DNS and/or designee to ensure that staff are performing proper hand hygiene. After which the results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. 5. Corrected by 6/28/21	

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F 880	Continued From page 12	F 880		

Continued From page 12
expected staff to wash or sanitize their hands when changing gloves, especially when going from dirty to clean to prevent transfer of body fluids, and prevent the spread of infections.

R2's quarterly MDS dated 2/8/21, identified R2 had severe cognitive impairment. R2 was frequently incontinent of bowel and bladder and required staff assistance to use the toilet. The MDS included diagnoses of stroke, Alzheimer's disease and chronic kidney disease.

On 5/12/21, at 7:50 a.m. NA-D assisted R2 with morning cares in the bathroom while R2 was seated on the toilet. NA-D put on clean gloves, assisted R2 to a standing position, and cleansed R2's perineal area of urine and stool. NA-D removed the soiled gloves, walked over to the sink area to retrieve clean gloves, and then put on clean gloves without performing hand hygiene. NA-D proceeded to apply ointment to the perineal area and continued to use the same gloves to put on incontinence brief and to assist R2 with putting on shirt and pants. No hand sanitizer was present in the bathroom.

R21's quarterly MDS dated 4/12/21, identified R21 had severe cognitive impairment. R21 was always incontinent of bowel and bladder, and fully dependent on staff for toileting/perineal hygiene. The MDS identifed diagnoses of stroke and dementia with behavioral disturbances.

On 5/12/21, at 10:17 a.m. NA-D checked R21's brief, removed her gloves, used a disposable

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F 880	Continued From page 13 washcloth to wash her hands and then put on clean gloves. NA-D stated R21's brief was soiled with stool and a small amount of urine. NA-D removed the soiled brief out from under R21, removed her gloves, used a disposable washcloth to clean her hands, donned clean gloves, then proceeded to clean R21 of urine and stool. NA-D wiped R21's perineal area with a disposable washcloth from front to back, folded it and used the same wipe again from front to back, and folded the wipe and used it a third time, also front to back. NA-D then discarded the disposable washcloth. Using dirty gloves, NA-D held the outside of an unopened tube of perineal barrier ointment, removed the cover, and applied the ointment to R21's perineal area. NA-D removed the soiled gloves and adjusted R21's blankets without performing hand hygiene. The tube of ointment was not disinfected after contact with NA-D's soiled gloves and was placed on the side table. During interview on 5/12/21, at 10:30 a.m. NA-D stated she used a disposable washcloth "in a pinch", to perform hand hygiene, as she did not want to leave the resident's side when changing the resident's brief. NA-D stated she should put on a clean glove, remove the brief, dispose of gloves, wash hands, and put on clean gloves before placing the clean brief. On 5/13/21, at 5:15 p.m. DON stated staff were expected to sanitize or wash their hands when going in and out of each room, and to wear gloves when providing hands-on cares, including when removing a resident's brief. If gloves were visibly soiled then the staff should remove the gloves, perform hand hygiene, let their hands	F 880		

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	245488	A. BUILDING ______ B. WING ______	05/14/2021

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F 880	Continued From page 14 dry, and put on clean gloves before proceeding. The DON clarified, if the resident could be cleaned up by wiping any fecal matter off using the brief and a disposable washcloth and the gloves were not visibly soiled, she did not expect staff to perform hand hygiene in between glove changes. She stated the need to change gloves "depended on the size of the mess", and she would expect good sanitation at the end of cares. Further, when using ointment, staff were to clean the resident, put on clean gloves before applying ointment and change gloves again after application. Staff would have to leave the resident to go into the bathroom to wash their hands between glove changes, as they did not have hand sanitizer in the rooms. The DON confirmed the policy directed staff perform hand hygiene between glove changes, but stated the facility was not "set up that way", and expressed concern the presence of dispensers in each room might be a safety concern with residents. The facility policy Hand Hygiene and Handwashing - Rehab/Skilled, Senior Living revised 4/6/21, directed staff to wash hands with soap and water or utilize hand sanitizer after removing gloves. The facility policy Putting On/Taking Off Personal Protective Equipment (Donning/Removing)- Rehab/Skilled, Senior Living, Child Daycare Services, Therapy revised 11/17/20, requires staff to "Always wash hands between gloving".	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		6/18/21

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F 921	Continued From page 15 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the walls, ceiling, floor, and floor mat in the ice machine alcove in good repair and/or a clean and sanitary condition within the resident dining room for 13 of 13 residents (R2, R7, R8, R13, R14, R15, R18, R21, R22, R23, R24, R25, R26) who dined regularly in the dining room. Findings include: On 5/10/21, at 5:56 p.m. the ice machine alcove in the dining room was observed. A large piece of wallpaper was removed and the sheet rock was missing from the kitchen-side of the space exposing the pipes and supply lines which were jutting out from the opening. Another smaller piece of sheet rock was missing from the same wall closer to the ceiling. The upper corner of the wall near the ceiling was visibly soiled with thick dust and dirt. A ceiling tile and light fixture had visible water damage. The black rubber matt covering the floor contained small holes approximately 1/2 inch (in) by 2 in's in parallel rows from end to end. The matt was visibly soiled, and when lifted a grid of black dirt remaining on the floor where the dirt had collected in the holes of the matt and around the edges at the base of the walls. During an interview on 5/12/21, at 2:54 p.m. nutrition services supervisor (NSS) stated the ice machine area was on a maintenance schedule. There was a plan to fix the area but due to	F 921	1. On 5/13/21 the area surrounding the ice machine was cleaned, a clean mat was put down, and a cleaning schedule was created for the area that was assigned to dietary to maintain. Maintenance repaired the sheet rock in the area of concern, and installed a new vanity and sink on 6/1/21. 2. All residents are at risk for infection or injury due to failure to preform regular cleaning and maintenance. 3. A cleaning schedule has been created and implemented. Additionally, all staff have been educated to observe for and report any concerns regarding cleanliness of the center and the connection to infection control via all staff meetings held on Wednesday 6/9/21 and 6/11/21 at multiple times by DNS and/or designee as to the importance of a clean facility free of maintenance issues in reducing the chances of infection or injury. 4. The director of maintenance or designee will audit the building weekly for areas of concern for maintenance for six weeks. Additional the director of maintenance or designee will audit ice machine area to ensure that the cleaning schedule is followed 3 times a week for 6 weeks. They will report their findings to the QAPI committee after which the	

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F 921	Continued From page 16 COVID-19 the facility could not have people come into the building. Further, the floor in the ice alcove was the responsibility of housekeeping. During interview on 5/13/21, at 12:40 p.m. maintenance supervisor (MS) stated the area where the ice machine was stored had a leaky water supply pipe behind a cabinet approximately one year ago. The damaged cabinet was removed along with a portion of sheet rock. MS measured the opening and identified it was approximately 53 in. from the floor to the top of the hole . was 16 in. wide at its widest point at the bottom, and 2.5 in. wide toward the top of the opening. There was a capital budget request submitted to the corporate office to reconstruct the area to include a sink and felt it would be dealt with at that time, but all progress was halted with the COVID-19. Further since it had been about a about a year, the construction project would likely not happen any time soon so they "probably" needed to patch, paint, and re-install the cabinet. During interview on 5/13/21, at 12:54 p.m. environmental services supervisor (EVS)-A stated the ice machine alcove was cleaned by dietary staff, but every once in a while housekeeping would do a deep clean. There was no written schedule for this area, but it was cleaned approximately one month ago. Further, it was due for a deep clean and stated, "I think that is really gross, actually". During interview on 5/13/21, at 5:49 p.m. the administrator stated there was a remodeling project scheduled before COVID-19 that had	F 921	results of the audits will be reviewed by the QAPI committee and they will give direction for any further needed action. 5. Corrected by 6/18/21	

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F 921	Continued From page 17 gone by the wayside and agreed the ice machine area was "not good". A policy regarding facility maintenance was requested but not provided.	F 921		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2021

Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Re: State Nursing Home Licensing Orders
Event ID: PXPU11

Dear Administrator:

The above facility was surveyed on May 10, 2021 through May 14, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00956	A. BUILDING: ______ B. WING ______	05/14/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/10/21 through 5/14/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide timely repositioning assistance for 1 of 1 residents (R21) who was at risk for pressure ulcer. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/12/21, identified R21 had severe cognitive impairment. R21 was totally dependent on staff and required assistance with transferring and bed mobility. R21 was at risk for pressure ulcers, and was on a turning/repositioning program as an intervention. The MDS did not identify R21 had any current pressure ulcers. R21's diagnoses included stroke, diabetes, and Alzheimer's disease.	2 905	Corrected	8/13/21

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2 905	Continued From page 3	2 905		

R21's Positioning Assessment and Evaluation dated 4/12/21, directed staff to reposition R21 every two hours.

R21's care plan dated 1/14/21, identified R21 was at risk for pressure ulcer development and directed staff to reposition R21 every two hours.

During continuous observations on 5/12/21, R21 was dressed and seated upright in her wheelchair in the doorway of her room from 7:07 a.m. until 8:11 a.m. when an unidentified staff person wheeled R21 to the dining room and set her at a table for breakfast.

- At 8:47 a.m. R21 was wheeled back to her room by unidentified staff following breakfast where she remained seated in her wheelchair.

- At 9:14 a.m. nursing assistant (NA)-D entered R21's room and reclined R21's wheelchair to approximately 20 degrees; However, was not offloaded to reduce pressure to her buttocks.

- At 9:38 a.m. NA-D peered into R21's room and then continued walking down the hall.

- At 9:50 a.m. R21 remained reclined in her wheelchair.

During an interview on 5/12/21, at 10:05 a.m. NA-D stated R21 got up a little before 7:00 a.m. and staff would be repositioning the resident soon. NA-D stated R21 needed to be repositioned every two or three hours. NA-D defined repositioning as laying down, as R21 was unable to stand, and stated she was not aware of any recent pressure ulcers for R21.

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2 905	Continued From page 4 On 5/12/21, at 10:13 a.m. NA-A and NA-D were present in R21's room where R21 was repositioned from her wheelchair to her bed using a mechanical lift [3 hours and 6 minutes after the previous repositioning]. NA-D checked and changed R21's brief and protective barrier cream was applied. R21's buttocks was intact without any redness or pressure ulcers. During interview on 5/13/21, at 1:07 p.m. NA-A and NA-E stated the Kardex outlined each resident's needs including repositioning and how frequently to check and change a resident's incontinence brief. R21's Kardex dated 5/13/21, instructed staff to notify the nurse of any new skin issues, provide a pressure relieving mattress and wheelchair cushion, and apply topical barrier cream to buttocks to prevent skin conditions; however, the Kardex lacked any instruction to reposition R21. During interview on 5/13/21, at 3:10 p.m. registered nurse (RN)-A stated R21 should be repositioned every two to three hours. Upon review of the care plan, RN-A clarified the care plan instructed staff to reposition every two hours and did not direct staff to reposition every two to three hours. On 5/13/21, at 3:18 p.m. licensed practical nurse (LPN)-A reviewed R21's care plan and stated R21 should be repositioned every two hours. Further, the repositioning instruction in the care plan was not linked to the Kardex, therefore it would not appear on the Kardex for the nursing assistants to follow. LPN-A was unsure how to make the edit to ensure the direction showed on	2 905		

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2 905	Continued From page 5 the Kardex. During interview on 5/13/21, at 5:15 p.m. the director of nursing (DON) stated R21 should be repositioned at a minimum of every two hours, but more often if there were skin issues. Further, three hours was an "unacceptable" length of time to go without being repositioned for R21. The facility Skin Assessment Pressure Ulcer Prevention and Documentation Requirements - Rehab/Skilled policy reviewed 4/21/21, directed staff to reposition residents who were unable to reposition themselves as often as directed by the care plan. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents receive the repositioning assistance according the assessed need. The DON or designee could develop an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced	2 920		8/13/21

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2 920	Continued From page 6 by: Based on observation, interview and document review, the facility failed to provide assistance with activities of daily living (ADL) for 2 of 2 residents (R21, R7) who were dependent upon staff for assistance. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/12/21, identified R21 had severe cognitive impairment. R21 was always incontinent of bowel and bladder, and was fully dependent on staff for toileting and personal hygiene. R21's diagnoses included stroke, diabetes, kidney disease and Alzheimer's disease. R21's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 10/28/20, identified R21 had no functional bladder control. R21 was no longer able to sit up, required total physical assistance to manage incontinence, total mechanical lift to transfer, and was an assist of one to two staff to manage clothing, hygiene and incontinent products. R21 was no longer able to make their needs known. R21's care plan dated 1/14/21, directed staff to check and change the resident's incontinence brief every two hours. R21's current undated Kardex provided 5/13/21, instructed staff to check and change the resident's incontinence brief every two hours. During continuous observations on 5/12/21, R21 was dressed and seated upright in her wheelchair in the doorway of her room from 7:07 a.m. until 8:11 a.m. when an unidentified staff	2 920	Corrected	

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	00956	A. BUILDING: ______ B. WING ______	05/14/2021

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2 920		2 920		

Continued From page 7

person wheeled R21 to the dining room and set her at a table for breakfast.

-At 8:47 a.m. R21 was wheeled back to their room by an unidentified staff following breakfast where she remained seated in her wheelchair.

-At 9:14 a.m. nursing assistant (NA)-D entered R21's room and reclined R21's wheelchair to approximately 20 degrees; however, did not check her brief.

-At 9:38 a.m. NA-D peered into R21's room and then continued walking down the hall, without checking to see if incontinence care needed to be completed.

-At 9:50 a.m. R21 remained reclined in her wheelchair.

During interview on 5/12/21, at 10:05 a.m. NA-D stated R21 got up a little before 7:00 a.m. and staff would be repositioning the resident soon. NA-D identified she looked at the care plan daily and stated R21 needed to be checked and changed every two or three hours as she was always incontinent.

On 5/12/21, at 10:17 a.m. NA-D and NA-A used a mechanical lift to transfer R21 from her wheelchair to her bed. NA-D checked R21's brief [3 hours and 10 minutes after the previous check] which was soiled with stool and a small amount of urine. The NA's provided peri care and placed a new incontinence brief. No redness was observed to R21's buttocks.

During interview on 5/13/21, at 1:07 p.m. NA-A and NA-E stated the Kardex identified R21

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2 920	Continued From page 8	2 920		

should be checked and changed every two hours.

During interview on 5/13/21, at 3:10 p.m. registered nurse (RN)-A stated R21 should be checked and changed every two to three hours. Upon review of the care plan, RN-A clarified the care plan instructed staff to check and change every two hours and did not direct staff to go up to three hours.

During interview on 5/13/21, at 5:15 p.m. the director of nursing (DON) stated R21 should be checked, changed, and repositioned at a minimum of every two hours, and three hours was an "unacceptable" length of time to go without being checked.

The policy Activities of Daily Living - Rehab/Skills revised 12/28/21, directed staff to provide appropriate treatment to maintain the residents activities of daily living including cleaning after elimination and the changing of protective pads.

R7's quarterly MDS dated 3/8/21, indicated R7 had severe cognitive impairment with no behavioral issues related to refusal of cares. R7 required extensive assistance for personal hygiene/grooming. R7's diagnoses included Alzheimer's disease and metabolic encephalopathy (damage or disease that affected the brain which was not due to injury).

R7's care plan dated 1/27/20, identified R7 preferred to be shaved daily during evening cares.

During observation on 5/10/21, at 5:09 p.m. R7 had rough stubble and was not clean shaven.

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2 920	Continued From page 9	2 920		

During observation on 5/12/21, at 7:20 a.m. R7 had rough stubble and was not clean shaven. During observation on 5/12/21, at 9:55 a.m. R7 had rough stubble and was not clean shaven. During observation on 5/13/21, at 9:30 a.m. R7 had rough stubble and was not clean shaven.

During interview on 5/13/21, at 9:33 a.m. R7 stated he liked to be clean shaven and preferred to be shaved daily. He did not like having stubble on his face.

During interview on 5/13/21, at 9:35 a.m. (NA)-A stated R7 should be shaved daily and it was on his care plan. Further R7 had not been shaved since 5/10/21.

R7's progress notes from 1/1/21, through 5/10/21, did not identify R7 had refused any offered to shave.

During interview on 5/13/21, at 9:36 a.m. trained medication assistant (TMA)-A identified R7's care plan indicated R7 liked to be shaved daily and did not know the last time R7 was shaved. TMA-A stated they did not document resident refusals.

During an interview on 5/13/21, at 4:12 p.m. DON stated R7 had facial hair and had not been shaved. Further, there were no refusals of shaving documented. The DON expected R7's care plan to be followed and for R7 to be clean shaven. If a resident refused it should be documented.

The facility policy Activities of Daily Living (ADL) dated 12/28/20, indicated ADL's are those necessary tasks conducted in the normal course

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2 920	Continued From page 10 of a resident's daily life and identified shaving as daily hygiene/grooming. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could educate responsible staff to provide care to residents who are dependant on facility staff, based on the residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was performed to prevent cross contamination for 3 of 4 residents (R26, R2, R21) observed during personal cares. Findings include: R26's quarterly Minimum Data Set (MDS) dated 4/26/21, indicated R26 had severe cognitive impairment. R26 required extensive assistance with all activities of daily living (ADL's). R26's diagnoses included non-Alzheimer's dementia,	21375	Corrected	8/13/21

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21375	Continued From page 11 stroke and epilepsy. During observation of moring cares on 5/12/21, at 7:39 a.m. nursing assistant (NA)-C entered R26's room to assist her with getting up and ready. NA-C sanitized her hands and donned a clean pair of gloves. NA-C removed R26's blanket and assisted R26 to sit on the edge of the bed. R26's bed was saturated with urine. R26 was assisted to the bathroom where NA-C removed her urine saturated brief and assisted R26 onto toilet. NA-C assisted R21 with puting on her foot wear and assisted her to get her pants on and got a new brief ready for the resident. NA-C did not remove her gloves or perform hand hygiene after removing the saturated brief. With the same dirty gloves NA-C started preparing a clean wash basin. NA-C then removed the dirty gloves; however, did not wash or sanitizer her hands and then put on clean gloves using dirty hands. NA-C then started to assist R26 to wash her face and upper body. NA-C then assisted her with dressing her upper. NA-C assisted R26 to stand and NA-C removed her dirty gloves. NA-C did not wash or sanitize her hand and then put clean gloves on her using dirty hands. NA-C washed and dried R26's groin and buttocks, applied a barrier cream on R26's bottom then pulled up the brief and her pants. NA-C assisted R26 to the wheel chair. NA-C then removed the dirty gloves; however did not wash or sanitize hands and put clean gloves on using dirty hands and assisted R26 to brush her teeth, wash up around her eyes and comb her hair. After R26 went for breakfast, NA-C stripped the bed, gathered linens and brought them to the dirty utility room. NA-C then removed her gloves and washed her hands with	21375		

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21375	Continued From page 12 soap and water. During interview on 5/12/21, at 8:18 a.m. NA-C stated she should of either washed or sanitized her hand between glove changes, especially when going from dirty to clean to prevent the spreading urine or feces to other areas. NA-C stated she did not wash or sanitizer her hands between glove changes when caring for R26. During interview on 5/13/21, at 4:12 p.m. the director of nursing (DON) stated she would have expected staff to wash or sanitize their hands when changing gloves, especially when going from dirty to clean to prevent transfer of body fluids, and prevent the spread of infections. R2's quarterly MDS dated 2/8/21, identified R2 had severe cognitive impairment. R2 was frequently incontinent of bowel and bladder and required staff assistance to use the toilet. The MDS included diagnoses of stroke, Alzheimer's disease and chronic kidney disease. On 5/12/21, at 7:50 a.m. NA-D assisted R2 with morning cares in the bathroom while R2 was seated on the toilet. NA-D put on clean gloves, assisted R2 to a standing position, and cleansed R2's perineal area of urine and stool. NA-D removed the soiled gloves, walked over to the sink area to retrieve clean gloves, and then put on clean gloves without performing hand hygiene. NA-D proceeded to apply ointment to the perineal area and continued to use the same gloves to put on incontinence brief and to assist R2 with putting on shirt and pants. No hand sanitizer was present in the bathroom. R21's quarterly MDS dated 4/12/21, identified	21375		

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21375	Continued From page 13 R21 had severe cognitive impairment. R21 was always incontinent of bowel and bladder, and fully dependent on staff for toileting/perineal hygiene. The MDS identifed diagnoses of stroke and dementia with behavioral disturbances. On 5/12/21, at 10:17 a.m. NA-D checked R21's brief, removed her gloves, used a disposable washcloth to wash her hands and then put on clean gloves. NA-D stated R21's brief was soiled with stool and a small amount of urine. NA-D removed the soiled brief out from under R21, removed her gloves, used a disposable washcloth to clean her hands, donned clean gloves, then proceeded to clean R21 of urine and stool. NA-D wiped R21's perineal area with a disposable washcloth from front to back, folded it and used the same wipe again from front to back, and folded the wipe and used it a third time, also front to back. NA-D then discarded the disposable washcloth. Using dirty gloves, NA-D held the outside of an unopened tube of perineal barrier ointment, removed the cover, and applied the ointment to R21's perineal area. NA-D removed the soiled gloves and adjusted R21's blankets without performing hand hygiene. The tube of ointment was not disinfected after contact with NA-D's soiled gloves and was placed on the side table. During interview on 5/12/21, at 10:30 a.m. NA-D stated she used a disposable washcloth "in a pinch", to perform hand hygiene, as she did not want to leave the resident's side when changing the resident's brief. NA-D stated she should put on a clean glove, remove the brief, dispose of gloves, wash hands, and put on clean gloves before placing the clean brief.	21375		

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21375	Continued From page 14	21375		

On 5/13/21, at 5:15 p.m. DON stated staff were expected to sanitize or wash their hands when going in and out of each room, and to wear gloves when providing hands-on cares, including when removing a resident's brief. If gloves were visibly soiled then the staff should remove the gloves, perform hand hygiene, let their hands dry, and put on clean gloves before proceeding. The DON clarified, if the resident could be cleaned up by wiping any fecal matter off using the brief and a disposable washcloth and the gloves were not visibly soiled, she did not expect staff to perform hand hygiene in between glove changes. She stated the need to change gloves "depended on the size of the mess", and she would expect good sanitation at the end of cares. Further, when using ointment, staff were to clean the resident, put on clean gloves before applying ointment and change gloves again after application. Staff would have to leave the resident to go into the bathroom to wash their hands between glove changes, as they did not have hand sanitizer in the rooms. The DON confirmed the policy directed staff perform hand hygiene between glove changes, but stated the facility was not "set up that way", and expressed concern the presence of dispensers in each room might be a safety concern with residents.

The facility policy Hand Hygiene and Handwashing - Rehab/Skilled, Senior Living revised 4/6/21, directed staff to wash hands with soap and water or utilize hand sanitizer after removing gloves.

The facility policy Putting On/Taking Off Personal Protective Equipment (Donning/Removing)-Rehab/Skilled, Senior Living, Child Daycare Services, Therapy revised 11/17/20, requires

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21375	Continued From page 15 staff to "Always wash hands between gloving". SUGGESTED METHODS OF CORRECTION: The DON or designee could develop, review, and /or revise policies and procedures related to hand hygiene to ensure appropriate hand hygiene during personal cares. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society, Woodland was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 06/11/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society, Woodland is a 1-story building without a basement. The building was constructed in 1982 and was determined to be of Type V(111) construction. The building is separated from the apartment building with a 2-hour fire barrier and is divided into 3 smoke zones with 1-hour fire barriers. The building is fully sprinkler protected and has a	K 000		

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K 000	Continued From page 2 fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 26 at the time of the survey. The requirements of 42 CFR, Subpart 483.70(a) are NOT MET.	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		6/9/21

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GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE** **BRAINERD, MN 56401**

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that the semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed per NFPA 101 (2012), section 9.2.3 and NFPA 96 (2011), section 11.4, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect the residents within the room. Findings Include: On 05/12/2021 at 9:30 a.m., during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility did not complete 1 of 2 semi-annual kitchen hood suppression system inspections within the last 12 months. This deficient condition was confirmed by a Maintenance Supervisor.	K 324	Disclaimer Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. Inspection of the kitchen hood ventilation and fire suppression system was completed by Brothers Fire Protection Co. of St. Cloud, MN on June 9, 2021. 2. A document was created and added to duty calendar of the environmental services director to serve as a reoccurring reminder of the need to complete this task going forward on a required basis. 3. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency.	

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	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING ______	**05/12/2021**

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K 324	Continued From page 4	K 324	4. Environmental services director 5. Corrected by 6/9/2021	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility has not maintained the fire alarm system testing and maintenance documentation in accordance with NFPA 101 Life Safety Code 2012 edition, section 9.6.1.3 and NFPA 72 National Fire Alarm Code 2010 edition, section 14.3.1. This deficient practice could affect 42 of 42 residents. Findings include: On 05/12/2021, at 10:19 a.m., during the review of all available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Supervisor it was revealed that the facility did not conduct a semi-annual visual inspection of the fire alarm initiating devices.	K 345	1. The environmental services director preformed visual inspection on all initiating devices on 6/9/21 The visual inspection included looking for damage, placement, and cleanliness in addition to looking for the light on the detector to flashing. Inspection was documented. 2. A document was created and added to duty calendar of the environmental services director to serve as a reoccurring reminder of the need to complete this task going forward on a required basis. 3. The environmental services director will be responsible for correction and monitoring to prevent a reoccurrence of this deficiency. 4. Environmental services director	6/9/21

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K 345	Continued From page 5 This deficient condition was confirmed by a Maintenance Supervisor.	K 345	5. Corrected by: 6/9/21	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 101 Life Safety Code 2012 edition, section 9.7.1.1 and NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition section 6.2.7. The failure to maintain the sprinkler system in compliance with NFPA 13 (2010) could allow the system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect the residents with the	K 351	1. The missing escutcheon ring on the noted fire sprinkler was replaced by the environmental services director on June 6, 2021. 2. A document was created and added to duty calendar of the environmental services director to serve as a reoccurring reminder of the need to complete this task going forward on a regular basis.	6/6/21

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K 351	Continued From page 6 room. Findings include: On 05/12/2021, at 10:49 a.m. during the facility tour, it was observed that the escutcheon ring was missing from the fire sprinkler head that is located in the freezer in the kitchen. This deficient condition was confirmed by a Maintenance Supervisor.	K 351	3. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency. 4. Environmental services director 5. Corrected by 6/6/2021	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on staff interview and a review of the	K 353	1. The environmental services director	5/28/21

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K 353	Continued From page 7 available fire sprinkler test and inspection documentation, the automatic sprinkler system is not maintained in accordance with NFPA 101 Life Safety Code 2012 edition, sections 9.7.5 and 9.7.8, and NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems 2011 edition section 5.2.5 and 5.3.2.1. The failure to maintain the sprinkler system in compliance with NFPA 25 (11) could allow the system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 42 of 42 residents. Findings include: 1. On 05/12/2021, at 9:15 a.m., during the review of all available fire sprinkler test and inspection documentation and interview with the Maintenance Supervisor it was revealed that the facility could not provide 3 of 4 quarterly flow tests and inspection documentation for the fire sprinkler system. 2. On 05/12/2021, at 10:59 a.m., the gauge that is on the main fire sprinkler riser in the mechanical room appears to have been manufactured in 2013 and is older than 5 years and the gauge did not have any annotation that it had been re-calibrated within the last 5 years These deficient conditions were verified by the Maintenance Supervisor.	K 353	completed a test and documentation of the fire sprinkler system on May 21, 2021. Additionally the environmental services director replaced a gauge on the fire sprinkler riser in the mechanical room with a new calibrated gauge on May 28, 2021. 2. A document was created and added to duty calendar of the environmental services director to serve as a reoccurring reminder of the need to complete this task going forward on a regular basis. 3. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency. 4. Environmental services director 5. Corrected by 5/28/2021	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		6/6/21

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K 761	Continued From page 8 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility did not complete the annual fire door inspections in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 8.3.3.1, 19.7.6 and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition sections 5.2.1. This deficient practice could affect the safety of 42 of 42 residents. Findings include: On 05/12/2021, at 9:45 a.m., during a review of all available fire door test and inspection documentation and an interview with the Maintenance Supervisor, that at the time of the inspection the facility could not provide documentation verifying that the fire door inspection had been completed within 12 months of the last annual fire door inspection that was conducted on 03/04/2020.	K 761	1. Fire doors were tested and inspected by the environmental services director on June 6, 2021 and documented the results. 2. A document was created and added to duty calendar of the environmental services director to serve as a reoccurring reminder of the need to complete this task going forward on a regular basis. 3. The environmental services director will be responsible for correction and monitoring to prevent reoccurrence of this deficiency. 4. Environmental services director 5. Corrected by 6/6/2021	

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K 761	Continued From page 9 This deficient condition was confirmed by a Maintenance Supervisor.	K 761		